

S. No. 2  
—1-4-41  
5-17-39  
P1 X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILLED NOV 25 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34459  
Registrar's No. 428

Registration District No. \_\_\_\_\_

Primary Registration District No. 5181

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Two years  
years, months or days

3. (a) PRINT FULL NAME Jack Weeks

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 2 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 16 1881  
(Month) (Day) (Year)

8. AGE: Years 60 Months 1 Days 25 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Columbus Miss  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name James Weeks  
13. Birthplace Columbus Miss  
(City, town, or county) (State or foreign country)  
14. Maiden name Caroline Moore  
15. Birthplace Columbus Miss  
(City, town, or county) (State or foreign country)

16. (e) Informant Evelina Washington  
(b) Address Malden R#2 Mo  
17. (a) Burial (b) Date thereof 11-12-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Marrocco

18. (a) Signature of funeral director Bernie  
(b) Address Mo  
19. (a) 11-12-41 (b) Belle Rime  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. near Providence  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11  
year 1941 hour 4 minute A M.  
21. I hereby certify that I attended the deceased from Nov 10 to Nov 11 1941  
that I last saw him alive on Nov 10 19 41  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia - Bilateral  
Duration 1 week

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions 108  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury MD  
23. Signature A. F. Brooks  
Address Poplar Bluff Mo Date signed 11-11-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 1141-1577

Date Filed 11/24/41

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**